Massage Intake Form

Personal information			
First name:		**Last name:**	
Date of birth:		**Gender:**	
Address:	**City:**	**State:**	**Zip code:**
Contact number:		**Email:**	

Emergency contact		
Full name:	**Relationship:**	**Contact number:**
Full name:	**Relationship:**	**Contact number:**

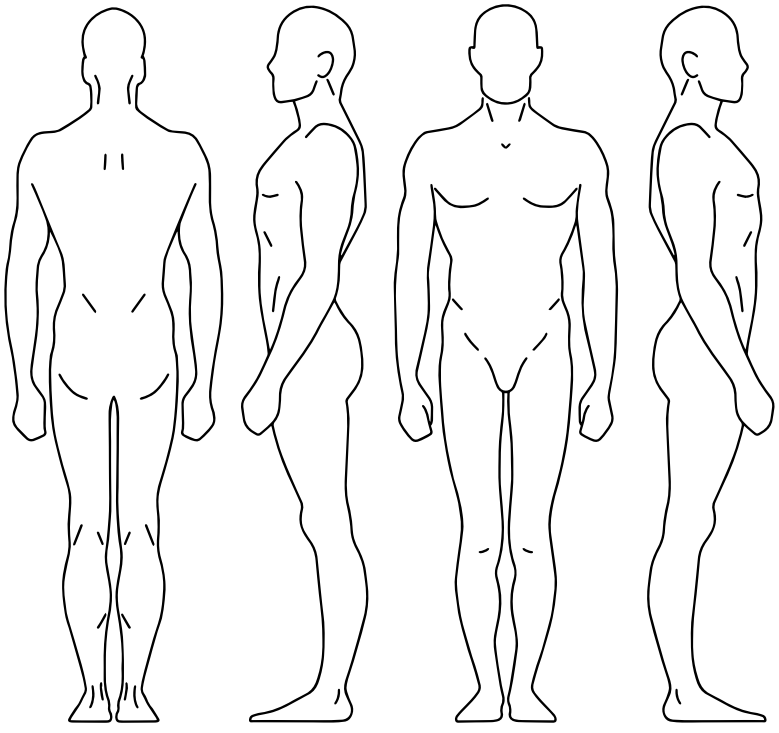
Medical information		
Please list any medical conditions or health problems you have had in the past or present:		
Are you taking any medications?	**Do you suffer from chronic pain?**	**Have you had any orthopedic injuries?**
◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
If yes, please specify:	If yes, please explain (including what makes it better or worse):	If yes, please list:

Massage information	
Have you had a professional massage before?	**What type of massage are you seeking?**
◯ Yes ◯ No	◯ Relaxation ◯ Therapeutic/Deep tissue ◯ Other:

Do you have any allergies or sensitivities?	Are there any areas (feet, face, abdomen, etc.) that you do not want to be massaged?
◯ Yes ◯ No	◯ Yes ◯ No
If yes, please explain:	If yes, please explain:

What are your goals for this treatment session?

Please indicate or describe any area of discomfort:



Adhesion
Rotation
Pain
Tender joint
Hypertonicity
Spasm
Inflammation
Trigger point
Elevation

Insurance information	
Insurance carrier:	**Insurance plan:**
Contact number:	**Policy number:**
Group number:	**Social security number:**
Authorization	
By signing below, you agree to the following: I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information change at any time.	
Client name and signature	**Date**
Therapist name and signature	**Date**